Children's Community Physicians Association (CCPA) uses the Illinois Department of Public Health's (IDPH) Health Care Professional Credentialing and Business Data Gathering Form (IL application) as the official initial credentialing application for the CCPA credentialing process. Please view detail instructions below on how to complete each section of the IL application.

Getting Started

To complete the IL application, you will need the support documents listed below. Please note you are required to submit your support documents to CCPA along with the IL application.

- □ All Current Professional License(s)
- Current Federal D.E.A. Certificate
- □ Current State Controlled Substance Certificate(s)
- □ Current Certificate of Insurance
- **ECFMG** Certificate (if applicable)
- Copies of Diploma(s), Residency Certificate(s), Fellowship Certificate(s) as applicable
- □ Current Curriculum Vitae
- Board Certification Certificate or Letter from ABP with Effective Date

IDPH Health Care Professional Credentialing and Business Gathering Form

The sections highlighted in yellow or green or outlined in red are to be filled out in its entirely if applicable.

Affirmation of Information – pg. 2

Page two (2) of the IL application is affirming that all the information listed on the application is complete and true to the best of your knowledge. Once this page is signed and submitted to CCPA, the applicant is the only person who can make changes to the IL application. See Figure 1.

and copies o	s A-F as needed to support "yes" responses in Section J: Professional Histor f the following: iculum Vitae
	iculum Vitae
	iculum Vitae
	All Current Professional Licenses
	Current Federal DEA License, If Applicable
	Current State Controlled Substance License(s), If Applicable
	Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amouat Displayed per Occurrence and In Aggregate
	Current CLIA Certificate, If Applicable
	Current W-9, If Applicable
	ECFMG Certificate, If Applicable
	Professional School Diploma, Residency Certificates, Fellowship Certificates, and Board Certifications, As Applicable
	AFFIRMATION OF INFORMATION
mplete to the ormation may ther agree to p pured to be u date Form.	varrant that all of the information provided and the responses given are correc best of my knowledge and belief. I understand that falsification or omissi be grounds for rejection or termination, in addition to any penalties provided by promptly inform all entities to which this form was sent and not rejected of any c pdated by the Health Care Professional Credentialing and Business Data Gatt this application does not entitle me to participation in any hospital, health care of
mplete to the cormation may ther agree to p uired to be u date Form. nderstand that health plan.	best of my knowledge and belief. I understand that Talsification or omissi be grounds for rejection or terministion, in addition to any penalties provided by momptly inform all entities to which this form was sent and not rejected of any c pdated by the Health Care Professional Credentialing and Business Data Gatt this application does not entitle me to participation in any hospital, health care of Sign and Print Name
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mplete to the	best of my knowledge and belief. I understand that falsification or or

Figure 1 - IL App. Pg. 2

Chapter A: Practice and Professional Information – pg. 3

Page three (3) is the collection of general information about the physician. All areas of this section must be completed, even the *CONFIDENTIAL INFORMATION* section. If there is information on this page that you do not want to include because you are emailing it to CCPA. Please call a CCPA team member and they will take the sensitive information over the telephone. See Figure 2.

Fill out page completely, including the confidential information box.

Fill out page completely, including the confidential information box.

PRACT				
	SECTION A. GENERAL	INFORMATION		
Name:				
Last	First		MI	Degree
List other names by which you	a have beenknown:		First	MI
If you have been known by ot	her names, please explain why you	ir name changed:	11150	MI
Birth Date:Pla (mm/dd/yy)	ce of Birth: City	State	Cou	ntry
	Language Fluency of Applican	t: 🗆 English 🔲 Ot	her:	-
U.S. Citizen? 🗌 Yes 🔲 No		Spanish		
If no, do	you have a legal right to reside pe	rmanently and work in	the U.S.? 🔲 Y	es 🗌 N
	you have a legal right to reside pe	-	the U.S.? Y	
Resident Visa No:	you have a legal right to reside pe	-		
Resident Visa No: Social Security Number:	you have a legal right to reside pe	-		
Resident Visa No:	you have a legal right to reside pe	-		
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Figure 2 - IL App. Pg. 3

Section B. Professional Information pgs. 4 - 6

Section B of the application is for IL professional license, DEA, and state control substance information. All Indiana physicians, who do not have an IL professional license, please add you state professional license information in the *Current and Previous Professional License(s) in Other States.* Please note, if you list other state licenses on your application, submit a copy of the corresponding license in your completed application packet. See Figure 3.

Fill this section out if practicing in Indiana.

Complete for each *Specialty Section*, please be sure to answer the question about when you are taking the boards certification test if you currently are not board certified.

Note: if you have failed your board test, answer yes to question #8 on the *Disclosure Question* page 19 and complete Form A. See Figures 4-6.

	SECTION B. PROFESS	SIONAL INFORM	ATION	
ois Professional License	Number:			
	Yes 🗋 No 🗖 🛶		imitation:	
	essional License(s) in Other License #:			
	Yes No			
tate:	License #:		Exp. Date <u>:</u>	(mm'dd/y
License Unlimited?	Yes 🗌 No 🗖 🛶	If No, please explain l	imitation	
ate:	License #:		Exp. Date:	(mm/dd/y
License Unlimited?	Yes 🗋 No 🗖	If No, please explain l	imitation	
and a manufacture of the state of the	xpiration Date.			
If No, please explai	n imitation:			
Check here if you have	e appended additional infor	nation for this section	ι: 🗌	
Check here if you have	e appended additional infor e Controlled Substance Nur CONFIDENTLA	nation for this section nber(s): . INFORMATION	n 🗌	
Theck here if you have ent and Previous State ute.	appended additional infor e Controlled Substance Nur CONFIDENTIAL CS License 8	nation for this section nber(s): . INFORMATION	Expiration Date:	(mm/dd/yy)
Check here if you have rent and Previous State	appended additional infor e Controlled Substance Nur CONFIDENTIAL CS License 8	nation for this section nber(s): 	Expiration Date:	

Figure 3 - IL app Pg. 4

Medicaid 109:	SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL
Check here if you have appended additional information for this section:	ADVERSE OR OTHER ACTIONS
COMPLETE FOR EACH SPECIALTY	Submit with all applications. Please answer the following questions to the best of your knowledg with a "yes" or "no." If you answer "yes" to any question(s) please complete Form A. Please mak copies of Form A as needed and complete one form for reach "yes" answer.
Specially I: Are you Board Cettined in Specially?? Ver No III If Yes many of Certifying Board:	 Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn?
In the set many of the mining from Date of Certification: <u>unmysy</u> <u>unmysy</u> <u>(mmysy)</u> <u>(mmysy)</u> <u>(mmysy)</u> <u>(mmysy)</u> <u>(mmysy)</u> <u>(mmysy)</u> <u>(mmysy)</u>	 Have you ever been reprimanded and/or fined, been the subject of a comphain and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, evil or disciplinary action by any state or federal agency which increase providen?
If Certifying Boards taken, give date: Certification Expiration Date, if Any:	 Have you lost any board certification(s), and/or failed to recertify?
(mm/vy) (mm/yy) If not taken, date scheduled to take Specially Boards:	 Have you been examined by a Certifying Board but failed to pass?
controls of Certification controls of Recentification (if upplicable). controls of Certification: controls of Certification:	5. Has any information pertuining to you, including malpractice judgments and/or disciplinary science, very been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank? 6. Has your federal DEA number and/or state controlled substances license been restricted. Initiate, relinquished, suppended or veryeload, either volumarily or investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or corrolled substance registration? 9. Yes
If No, have you taken or are you scheduled to take the specialty hourds certification? Yes No If Certifying Poards taken, give date	Your Jack to consume transmission and the segment of the segm
(mm) (yy)	 Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason?
	9 Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory supery center privileges and/or your license?
(Please continue next page)	 Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or volurtarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmeniah health-related programs?
	 Haree Medicatee, Medicatek, CHAMPUS, PRO authorities and/or any other third party payors tronglet charges against you for alleged inappropriate fees and/or quality-of- care issues?
dib Care Payferwards Credentialing & Businew Data Gabering Form 5 Dicard Name	Health Care Professionals Credentialing & Business Data Gathering Form Applicant Name:

Figure 4 - IL app Pg. 5

Figure 5 - IL App Pg. 19

DUPI applie	ICATE this form as necessary to co s. Use reverse side of this form if ac	mplete separate sheet for EAC lditional space is needed.	H occurrence
Applicant Nam			
	Last	Pirst	
Indicate the nu	nber of ONE of the questions in Secti-	on J to which you answered "ye	s": Question Nu
A. Describe th	e circumstances surrounding this occu	rrence. Please include the date of	f the occurrence
B. Provide an	explanation of any actions taken. Pleas	se include the date the action wa	s taken.
C. Provide the	ourrent status of the issue.		
D. Ifknown	Contact:		
5. 11100.001	Department/Committee:		
	Address:		
	Street	City	State
	Telephone: ()		

Health Care Professionals Credentialing & Business Data Gathering Form Applicant Name:



Section C: Professional Liability Insurance pgs. 7-8

Section C requires that you list the malpractice insurance coverage that you had over the last ten (10) years (current and previous).

If you have been denied or voluntarily relinquished your professional liability insurance coverage, and/or had your professional liability insurance coverage canceled, non-renewed or limits reduced, please answers the *Liability Insurance* section questions on page 20. If you answer yes to any question, please complete Form C. See Figures 7-9.

Please provide information have received coverage in	n on all professional liability insurance the past 10 years.	carriers from whom you
CURRENT PROFESSIONAL	LIABILITY INSURANCE	
CONFIDENTIAL INFORMATIC	N:	
Carrier:		
Address:		
Street	City	State Zip
Policy Number:	Original Effective Date:	Expiration Date:
Policy Limits: Per Occurrence: \$	Aggregate: \$	yy) (nm/dd/yy)
Retroactive Date:		
	? 🗌 Claims Made 🔄 Occur	

CONFIDENTIAL INFORMATION:			
Carrier:			
Addres <u>s:</u>			
Street	City	State	Zip
Policy Number.	Original Effective Date: (mm/dd/v		(mm/dd/vv)
Policy Limits: Per Occurrence: <u>\$</u>			(1115-05-55)
Retroactive Tate:			
What type of coverage do you have?	Claims Made Occurre	mae	

	Health Care Professionals Credentialing & Business Data Cathering Form Applicant Name:
Figure	7- IL App. Pg. 7

	Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, LPA, professional group or society, licensing board, certification board, PSRO, or PRO?	Tes 1	□ No
3.	Have you withdrawn an application or any pertion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an advense decision?	🗌 Yes	□ No
PR	OFESSIONAL LIABILITY ACTIONS		
	If you answer yes to any question(s) in this section please complete FORM B. Please m FORM B if needed, and complete one for each yes answer.	ake copies	of
1.	Have any professional liability judgments ever been entered against you?	🗖 Yes	🗆 No
2.	Have any professional liability claim settlements ever been paid by you and/or paid on your behall?	🔲 Yes	□ No
3.	Are there any currently pending professional liability suits, actions and/or claims filed against you?	TYes	🗖 No
			_
4.	Has any person or entity ever been sued for your clinical actions?	🗖 Yes	No No
LL	ABILITY INSURANCE If you answer yes to this question please complete FORM C. re you ever been denied or voluntarily relinquished your professional liability insurance	Tes Yes	□ No
LL	ABILITY INSURANCE If you answer yes to this question please complete FORM C.	☐ Yes	
LL/ Hav cov rens	ABILITY INSURANCE If you answer yes to this question please complete FORM C. you ever been denied or voluntarily relinquished your professional liability insurance rage, and/or have hdy our professional liability insurance coverage canceled, non-		
LL/ Hav cov rens	ABILITY INSURANCE If you answer yes to this question please complete FORM C: re you ever been denied or voluntarily relinquished your professional liability insurance erage, and/or have had your professional liability insurance coverage canceled, non- weed or limits reduced ?	Tes	□ No
LL/ Hav cov rens	ABILITY INSURANCE If you answer yes to this question please complete FORM C. re you ever been denied or voluntarily relinquished your professional liability insurance enge, and/or have hd your professional liability insurance coverage canceled, non- wed or limits reduced ? IMINAL ACTIONS If you answer yes to any question(s) in this section please complete FORM D. Please m	Yes	□ No of
LL Hav cov rens	ABILITY INSURANCE If you answer yes to this question please complete FORM C. re you ever been denied or voluntarily relinquished your professional liability insurance reage, and or have had your professional liability insurance coverage canceled, non- weed or limits reduced ? ININAL ACTIONS If you answer yes to any question(6) in this section please complete FORM D. Please an FORM D if needed, and complete one for each yes answer. Have you been charged with or convicted of a crime (other than a minor traffic	Yes	□ ^{No}

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed. Applicant Name:______Last First Ы A. History of Professional Liability Insurance (Please check One) Canceled Voluntarily Non-Renewed B. Carrier Name:____ C. Carrier Telephone Number: (_____) D. Policy Number: E. Carrier Address (Street, City, State, Zip Code): F. Dates of Covenage: From (mm/yy):_____ To (mm/yy):_____ G. Circumstances Involved: Signature:_____ ___Dute:___

FORM C - LIABILITY INSURANCE

Health Care Professionals Credentialing & Business Data Gathering Form Applicant Name:

FORM C

Figure 9 - IL App. Form C

Figure 8- IL App. Pg. 20

Section D: Education and Training pgs. 9-12

Section D. requires that you complete all sections that relates to your education and training. A signed and dated letter explaining a gap in your training of more than 30-days is required. Please submit the letter with your completed application.

All initial credentialing applications requires the applicant to submit a copy of their medical degree and residency certificate.

If you answer yes to graduating from a foreign medical school and are certified by the Educational Commission for Foreign Medical Graduates (ECFMG), please include a copy of your ECFMG certificate with the completed IL application. See Figure 10.

Membership Status – Use for Sections E, F, and G - pgs. 13-15

Please complete all the sections in the hospital membership status areas as it pertains to your current and previous privileges. **Note:** this does not include your hospital membership during your internship/residency and or fellowship.

If you have voluntarily or involuntarily relinquished or failed to seek renewal of your hospital privileges for any reason. Please answer question #8 on page 19 of Section J. and complete Form A. See Figures 11 - 14.

Section F: Fill out this section if you have held any previous hospital privileges.

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Mailing Address:			
Sheet Chy Safe Zap Topores Tack Number	Institution Name:		
Telephone Number Tex Number Papers Your Andread Dates attended Form To Trou are graduate of a foreign medical school are you eritified by the Educational Commission for Foreign Medical Graduated (FCMMO) You Not the foreign Medical Graduated (FCMMO) You set Device the school of any Medical revulues and the school are	Mailing Address:		
Deprese Year On AuxAcd Datase standad From			State Zip
Date attended Pon			
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* Were you the solphet of any disciplinary action during your attraduce athlis initiation" Yes (Attach on solphantion of a "Yes" move y	If you are a graduate of a foreign medical school, are you certifi Medical Graduates (ECFMG)?	ied by the Educational C	ommission for Foreign
* Wes you do subject of any diseplinary action during your action during the action during your action during you action during you action during your action during	Dete Issued: Nerial Number for	ECFMG:	
(Attach in explanation of a "No" insert a set of a s			
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type of internship: □ ¹ Koluting □ ¹ Sinaghi → If straight, please list specially: Lid you successfully complete that program? □ Yes □ No → If too, please attach an explanation. Were you the subject of any disciplinuty action during your attendance atthis institution? □ Yes □ No	hiplicates the information requested above INTERCENSULP resitution Nonne Partment Chara or Program Dareotor Lost Name_ Mailing Address Stood	First Name City	an explanation that Mi Degree
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Health Care Professionals Credentialing & Business Data Gathering Portri Applicant Name:

Figure 10 - IL App. Pg. 9

	ing key to indicate membership statu nt and Pending), F (Hospital Membe Center Practice) below.	
A. Active	E. Suspended / Terminated/ Resigned	I. Provisional
B. Courtesy	F. Active Provisional Staff	J. Affiliate
C. Consulting	G. Senior Staff	K. Pending
D. Adjunct	H. Associate	L. Other (Specify)
SECTION E. I	OSPITAL MEMBERSHIP - CURRE	NT AND PENDING
privileges or have app three hospitals.) ary Hospital		
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Figure 11 - IL App. Pg. 13

Health Care Professionals Credentialing & Rusiness Data Gathering Form

Hospital Name	
Address:	
Streat	City State Zip
Membership Status:	To: From (mm/ys) To (mm/ys)
	Medical Staff Office FAX #:()
Department Telephone # ()	
Any Limitations in Your Area of Specialty at t	hisHospital?
tere if you have appended additional information	ition for this section:
out this section if you have h	eld any previous hospital privile
out into beolion in you nave i	iela any previous nospital privile
SECTION F. HOSPITAL	MEMBERSHIP - PREVIOUS
Phone Ref. (R. Konerkelt, and an and	
	ously held privileges other than during your
	ously held privileges other than during your dembership Status key listed prior to Section E.
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	lembership Status key listed prior to Section E.
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DUPLICATE this form as necessary to complete separate sheet for EACH occurrence that applies. Use reverse side of this form if additional space is needed.					
\pplicant Nam					
	Last	First	M		
ndicate the nu	mber of ONE of the questions in	Section J to which you answered "yes"	Question Number		
 Describe th 	e circumstances surrounding this	occurrence. Please include the date of	he occurrence.		
Provide an	replanation of any actions taken	Please include the date the action was	aken		
	organizzation of the orthogonal states.	The actual and an actual the			
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	Contact: DepartmentCommittee				
C. Provide the	Contract Department/Committee:				
	Contact Department/Committee: Address	City			

Health Care Professionals Credentialing & Business Data Gathering Ferm Applicant Name:

FORM A

Figure 13 - IL App. Form A

Please answer all disclosure questions

Figure 12 - IL App. Pg. 14

Health Care Professionals Credentialing & Business Data Gathering Form Applicant Name:

	SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL		
Ð	VERSE OR OTHER ACTIONS		
1	Submit with all applications. Please answer the following questions to the best of y sith a "yes" or "no." If you answer "yes" to any question(s) please complete Form , soples of Form A as needed and complete one form for each "yes" answer;		
	Has your leaves to practice in any jurisdiction over here denied, restricted, limited, suspanded, revolved, canceled and/or subject to probation either volumarily or involuntarily, or has your application for a license ever been withdrawa?	🗖 Yes	□ No
	Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which "lecenses providers?"	U Yes	□ No
	Have you lost any board certification(s), and/or failed to recertify?	🔲 Yes	□ No
	Have you been examined by a Certifying Board but failed to pass?	🗆 Yes	□ Ne
	Has any information pertaining to you, including maloyactice judgments and/or d sc plinary action, ever hear reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank?	🗆 Y es	No No
	This year finders) DEA number and/or state controlled substates: license beer restricted, limited, rolniquished, associated or revolved, either voluntarily or mediatarily, makes have year over been notified in writing that you are being interedipted as they existed a signal of a cristiant or docyclinmy action with respect to your DEA or controlled audiators objection for the signal of th	🗖 Yes	□ No
	Have you, or any of your hospital or annoulatory surgery center privileges and/or membership been idenied, tevoked, suspended, reduced, placed on probation, processed, placed under mandatory consultation or non-renewed?	🗆 Yes	□ No
	Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgory center privileges for any reason?	Ves	🗆 Ne
	Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your heapital or ambu/anory surgery center privileges and/or your license?	Ves 🗌	□ No
ι.	Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs?	Ves.	□ No
	Have Medicare, Medicaid, CHAMFUS, FRO authorities and/or any other third party payera brought charges against you for alleged inappropriate fees and/or quality-of- eare issues?	Ves.	□ No
			1

Hotifti Care Prefessionals Credentialing & Business Duta Gathering Form Applicant Name

Figure 14 - IL App. Pg. 19

16

Section H: Work History – pgs. 16 – 17

Add your current work history (list the practice you are joining along with the start date). Include previous workplace, do not include your internship, residency, or fellowship information. If you have a 30-day or more gap in your work history, please sign and date a letter explaining the gap between employments. See Figure 15.

The dates of employments should include the month and year. Example: *From:* 01/1977 to: 10/1984. The dates on your CV should also be listed in the month/year format for your school and employment history.

List the practice you will be working at and the start date.

List chronologically (most recent first) all work en employment, service as an independent contractor, internohip, residency, and fellowship information pr greater than 30 days in chronology, explain it on a se	and military servic eviously reported. I	e). Do not duplicate
Current work place: Ust the practice you will be working a	t.	
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	nn/sy)	

Health Care Protossionals Codentiating & Business Data Gallening Form Applicant Neme:

Figure 15 - IL App. Pg. 16

Section I: Professional References pg. 18

List three physicians who in the last twelve months has personal knowledge of your current clinical abilities, ethical character, and interpersonal skills. Include all the information requested along with email addresses for each person. See Figure 16.

	months) of your cu would be willing	SECTION I. PROFESSIOn es of three individuals who here the indical abilities, ethics to provide this information pervide this information pervide this information pervide this information.	have personal d character an m upon requ	knowledge klinterpers kst. Do ne	onal skilla π list pa	and who there of	0 F
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(Please continue next page)

18

Hotch Le 2 Perfassionals Charlantia ing 4 Baninasa Dara Gadhan 19 Sonn Age coul Roma: Figure 16 - IL App. Pg. 18

Section J: Professional History Confidential pgs. 19-21

Answer all the questions with a yes or no. If you answer yes to any of the questions, please complete a corresponding Form A - F. All forms can be found at the end of the application. See Figure 17.

Please answer all disclosure questions.

Please answer all disclosure questions.

AD	WERSE OR OTHER ACTIONS		
2	Submit with all applications. Please answer the following questions to the best of y rith a "yes" or "no." If you maker "yes" to any question(s) please complete Form a optics of Form A as needed and complete one form for each "yes" answer;	our knowl 1. Please 1	edge un ke
	Has yory licease to practice in any jurisfiction ever beea denied, restricted, limited, suspended, revoked, canceled and/or subject to probation, either volunterity or involuntarily, or has your application for a hierose everbeen withdrawn?	□ Yes	
	Have you ever been repriminabled and/or lined, been the subject of a complicit and/or have you been multified in verting that you have hear investigated as the possible subject of a original, etcl or cleeplinary action by any state or faderat agoney which learness providers?	□ Yes	∎ N
	Lieve you lost any board certification(s), and/or failed to recertify?	🗌 Yes	D N
	Have you been examined by a Certifying Board but failed to pass?	🗌 Yes	۵N
	Has any information portaining to you, including malpractice judgments and/or dissiplinary action, ever been reported to the National Practicence Data Bank (NFDB) and/or any other practicence data bank?	∏ Yes	ШN
	Liss your federal 134A number arctiv state controlled substances licence been existing the first of relative systems of the substantial to obtain the two involutionality, and/or have you ever been netified as writing that you are being investigated as the persolite arctice of the control end controlled substance regionation?	□ Yes	N
	Have you, or any of your heapital or ambulatory surgery center privileges and/or membership been douled, revolved, attspended, redtoed, placed on projetion, proctored, placed under mandet.org consultation or networknewed?	🗆 Yes	DN
	Have you volustarily or involuntarily relinquished or fulled to acek reaewal of your hospital or ambulatory surgery center previleges for any reason?	🗌 Yes	۵N
	Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings new pending, with respect to your hespital or ambulatory surgery ocater provileges and/or your license?	🗖 Yes	∎ N
2	Have you ever teen reprimanded, cereared, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid, an investigation, in: Medsare, Medioxid, CHAMPUS and/or suy other; governmental health-related programs?	Ves	□ N
	Have Madicans, Medicaid, CHAMPUS, PRO natherities and/or any other third party payors brought charges against you for alloged impropriate fees and/or quality of care issues? \Box	🔲 Yes	∎ N

Hall & Care Franciscouls Credentialing & Business Data Cathering Fore Applicant Name Figure 17 - IL App. Pg. 19

Chapter B: Business Information Section K Primary Site Information pgs. 22-29

Fill out the business portion in its entirety. There is a section for primary site and any additional sites where you will provide treatment that is own by the practice. This information is used for linking physicians to managed care contracts. See Figure 18.

		SECTION	ONK. PRIMA	RY SITE INF	ORMATIO	N	
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	Darking	Noma					
	Dat ICH 2	i da le					
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	Oily .				County	State	Zip
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Miscellaneous Things to Know

When correcting/updating any portion of the application, please date and initial near each correction.

Please complete each section to the best of your knowledge.